STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155430	B. WING		05/26/2011	
NAME OF P	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
			I	18TH ST		
HICKOR'	Y CREEK AT ROCH	IESTER	ROCH	ESTER, IN46975		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	This visit was for	r the Investigation of	F0000	This Plan of Correction		
	Complaint IN000	_	1 10000	constitutes the written allega	ition	
	Complaint invoc	J90339.		of compliance for the deficien	ncies	
	Complaint INOO	090339 - Substantiated.		cited. However, submission		
	*	iciencies related to the		this Plan of Correction is not admission that a deficiency of	I	
				or that one was cited correct		
	anegations are ci	ted at F282 and F323.		This Plan of Correction is		
	TT 1 . 1 1 C .			submitted to meet requireme		
	Unrelated deficie	encies cited.		established by state and fed		
				law. Hickory Creek at Roche desires this Plan of Correction		
	Survey dates Mag	y 24, 25, and 26, 2011		be considered the facility's) i i i	
				Allegation of Compliance.		
	Facility number:			Compliance is effective on Ju	une	
	Provider number			24, 2011.		
	AIM number: 10	0290770				
	Survey team:					
	DeAnn Mankell,	R.N.				
	Census bed type:					
	SNF/NF: 33					
	Total: 33					
	Census payor typ	oe:				
	Medicare: 4					
	Medicaid: 21					
	Other: 8					
	Total: 33					
	Sample: 7					
	Sample.					
	These deficiencies also reflect state					
		dance with 410 IAC 16.2.				
	imanigs in accor	uance with 410 IAC 10.2.				
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T4FF11

Facility ID:

000326

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155430			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/26/2011
	PROVIDER OR SUPPLIER		STREET A 340 E 1	ADDRESS, CITY, STATE, ZIP CODE 18TH ST ESTER, IN46975	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	The services provifacility must be proin accordance with plan of care. Based on record facility failed to for alarm placem with falls in a sar. Finding include: Resident B's clos reviewed on 5/25 Resident B's diagnot limited to, A dementia, hypert obstructive pulm depression, and of Resident B's quade Data Set) assessindicated Reside impaired cognitive.	ided or arranged by the ovided by qualified persons in each resident's written review and interview, the follow a physician's order tent for 1 of 5 residents imple of 7 (Resident B). Seed clinical record was 5/11 at 11:30 A.M. Ignoses included, but were lizheimer's disease, ension, COPD (chronic onary disease), paranoia, dysphagia. Interly MDS (Minimum ment, dated 3/17/11, int B was severely evely. The assessment int B needed extensive	F0282	F282 It is the policy of this fato provide services which ar provided by qualified person accordance with residents' volans of care, including follo physician's orders for alarm placement. 1. What correctivaction will be done by the fatorial Resident B is no longer a resofthis facility. The DON has in-serviced 5/23/11, and will on 6/15/11, the nursing staff regarding the requirement to know residents who need all check each shift for function placement of alarm and that alarms must be moved with resident when repositioned ambulated. 2. How will the fidentify other residents having potential to be affected by the same practice and what corrective action will be taken for all residents currently us alarms, the type and position alarm has been re-assessed.	e sin vritten wing ve cility? sident s again arms, and the or acility ng the ne e e e e e e e e e e e e e e e e e

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155430	B. WIN			05/26/2	011
			B. ((1))		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			8TH ST		
HICKOR	Y CREEK AT ROCH	HESTER		1	ESTER, IN46975		
(X4) ID		STATEMENT OF DEFICIENCIES	_	ID	,		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	assistance of two	to transfer to and from			appropriateness. Fall risk		
		heelchair, toilet, and to			assessments have also beer	า	
		sment indicated she			completed with revised		
		e assistance of one person			interventions put into place to meet the assessed needs for		
		s assessed as not steady,			risk and prevention. In the fu		
		ilize with human			if the DON or designee obse		
	1				that a resident does not have		
		lance when standing,			alarm applied and in working		
	"	around and transferring			order, she will act immediate	-	
		e to another surface,			make sure that the alarm is in place and turned on so that in		
	_	ng. She used a wheelchair			working order. Once she is	(10 111	
		e moving through the			assured that the resident is s	afe,	
	1 *	OS indicated she had falls			she will re-train the staff invo		
		en admitted to the facility,			regarding the facility policy a		
	but she had no ir	njuries.			procedure for alarm applicati and use. She will also render		
					progressive disciplinary action		
	Resident B's Apı	ril 2011 and May 2011			deemed necessary for contin		
	monthly rewritte	en orders indicated orders			noncompliance up to, and		
	first written on 1	/24/2011 for "Sensor pad			including, termination. 3. Wh		
	while in bed. Ch	neck function every shift.			measures will be put into pla ensure this practice does not		
	Sensor pad while	e up in chair. Check			recur? The DON or designed		
	function every sl	•			review the application of alar		
					as part of regular rounds that	t are	
	The nurses' note:	s indicated on 5/12/11 at			done several times a day dui	-	
		dent got self up to walk			her tour of duty. In addition, s will check 3 residents per we		
	· ·	informing staff. Resident			determine consistency of ala		
		hitting head - goose egg			checks, accurate placement		
		head Assisted up to			alarms, whether or not the al		
		-			are in working order, and		
		rest of way to bed send			adequacy of fall risk interven		
	`	e) ER for evaluation &			overall. If any issues are ider or observed, the DON or	ııııea	
	treat"				designee will follow up as		
	The incident/accident investigation				indicated in question #2. On	the	
					week-ends and various shifts		
	1	alarm was not in use, and			charge nurse will be respons	ible	
	"forgot to put in	chair." The prevention			for checking the alarms for		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155430 05/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 340 E 18TH ST HICKORY CREEK AT ROCHESTER ROCHESTER, IN46975 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE was, "Remind staff to use alarm even placement and working order, and for adequacy of fall risk when transferred (Transfer alarm also)." interventions until IDT can review. The week-end manager During an interview with LPN #1, on will also check at least 3 residents during their tour of duty for alarm 5/25/11 at 3:05 P.M., she indicated she placement and working order. The had placed Resident B in her chair in front results of these checks will be of the nurses' station and gave her a snack. brought to the next scheduled LPN #1 was sitting at the desk charting, morning management meeting but when she looked up the resident was that meets at least 5 days a week for review by the interdisciplinary gone. She walked out of the nurses' team. Any recommendations station through the hall and around the made at that time will be followed corner, but when she got around the through by the DON. 4. How will corner, Resident B was falling onto the corrective action be monitored to ensure the deficient practice does floor. She said there was no alarm on the not recur and what QA will be put resident. The Administrator, who was into place? The DON or designee listening to the interview, indicated this will bring the results of their rounds and resident-specific was "human error." audits to the monthly QA&A committee for further review & This federal tag relates to Complaint recommendation for process IN00090339. improvement. Any recommendations made will be followed up by the DON who will 3.1-35(g)(2)report the results of the improved process at the next QA&A Committee meeting. The QA&A Committee may stop the specific resident reviews after 90 days when 100% compliance is achieved; however, continued monitoring of the alarm use during rounds will continue on an ongoing basis. Date of Compliance: 6/24/11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155430		A. BUILDING 00 COM			(X3) DATE S COMPL 05/26/2	ETED	
		100 100	B. WIN			00/20/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HICKOR	Y CREEK AT ROCH	ESTER		I	8TH ST ESTER, IN46975		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323 SS=G			F0323		F323 It is the policy of this facility to ensure that each resident receives adequate supervision and assistance devices to prevent		06/24/2011
	hematomas for 1 in a sample of 7. time of one fall, I was not in place, unsupervised. In required transfer for management hematoma and shpain. Finding include: Resident B's clos reviewed on 5/25 Resident B's diag not limited to, Al dementia, hypertone	of 5 residents with falls (Resident B). At the Resident B's chair alarm			and assistance devices to prevent accidents, including supervision to prevent falls that result in skin tears and hematomas. 1. What corrective action will be done by the facility? Resident B no longer resides in this facility. The DON has in-serviced on 5/23/11, and will again on 6/15/11, the nursing staff regarding the requirement to know residents who need alarms, check each shift for function and placement of alarm and that alarms must be moved with the resident when repositioned or ambulated. In addition, staff will be in-serviced 6/15/11 the need to re-evaluate the resident's fall risk after each fall and to develop/revise existing fall interventions to meet the results of that fall risk reassessment. 2. How will the facility identify other		
	Resident B's quan Data Set) assessmindicated Resident impaired cognitive indicated Resident	rterly MDS (Minimum nent, dated 3/17/11, nt B was severely vely. The assessment nt B needed extensive			be affected by the same prace and what corrective action we taken? For all residents currently using alarms, the type and position of alarm has been re-assessed for appropriate and position of alarm has been completed with revised interventions put into place to	ill be ently less.	
	assistance of two	to transfer to and from			meet the assessed needs for	ıaıı	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155430	B. WIN			05/26/2011	
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				8TH ST		
HICKOR	Y CREEK AT ROCH	IESTER		1	ESTER, IN46975		
						•	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E COMPLET	ION
IAG		LSC IDENTIFYING INFORMATION)	+	IAG	· · · · · · · · · · · · · · · · · · ·		
		heelchair, toilet, and to			risk and prevention. In the fu if the DON or designee obse	l l	
		sment indicated she			that a resident does not have	l l	
	needed extensive	assistance of one person			alarm applied and in working	l l	
	to walk. She was	assessed as not steady,			order, she will act immediate		
	only able to stabi	lize with human			make sure that the alarm is i	l l	
	assistance for bal	ance when standing,			place and turned on so that i	t is in	
		around and transferring			working order. If the	.p.	
		to another surface,			Administrator, DON, or other		
		g. She used a wheelchair			member observes that any fa intervention is not in place as		
		· ·			designated on the resident's	l l	
		e moving through the			plan, he/she will immediately		
	· ·	OS indicated she had falls			intervene with the staff and		
	after she had bee	n admitted to the facility,			resident to make sure that th	e	
	but she had no in	juries.			resident is safe. Once the		
					resident's safety is assured,		
	Resident B's Apr	il 2011 and May 2011			Administrator or DON will rev	<u>riew</u>	
	_	n orders indicated orders			the facility policy on utilizing interventions designated in t	ne	
	1 *	/24/2011 for "Sensor pad			residents' care plans, includi		
		eck function every shift.			the use of alarms, with the s		
		· ·			involved. In addition, progres	sive	
	_	up in chair. Check			disciplinary action will be util	<u>zed</u>	
	function every sh	11ft."			for continued instances of		
					noncompliance with facility p		
		ssessment" completed on			3. What measures will be pu place to ensure this practice		
	3/26/11, 4/10/11,	5/12/11, and 5/16/11,			not recur? An identifier will	l l	
	indicated a total	score of 23 on 3/26/11			used to let staff know who is	l l	
	and 22 on the las	t 3 dates. The key			risk of falling. Identifier will be	l l	
	indicated "If the	total score is '10' or			placed on name tag at door.		
		ent is considered at			will be in-serviced on the ide	l l	
	HIGH RISK for				and who is responsible for pl	acing	
	Interventions sho				identifier after fall risk assessment is completed.		
					Current residents' fall risk		
	immediately & th	ne care plan updated."			assessments have been revi	ewed	
					to assure that the assessme		
		plan for the problem of			accurate and consistent with		
	"I am at increase	d risk for falls. I require			resident's current status. The		
	a pressure alarm	on my chair and on my			care plan and CNA assignment	ent_	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155430	B. WIN			05/26/2	011
			В. ТП		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			8TH ST		
HICKOR	Y CREEK AT ROCH	HESTER		1	STER, IN46975		
			_	<u> </u>			975)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG	+	· · · · · · · · · · · · · · · · · · ·		IAG	sheets have been updated to	,	DAIL
		0/2010 with additional			include the appropriate fall	_	
		es of 1/10/11 and 3/23/11.			interventions determined by	the	
		s included, but were not			IDT as a result of the most re		
		y room will be kept free			fall risk assessments. The D	ON	
	from clutter. 3.	My call light will be			or designee will review the		
	within reach. 4.	My rollater walker will			application of alarms as part		
	be kept in my rea	ach. 5. I will call for			regular rounds that are done several times a day during he		
	assistance if need	ded. 8. My alarms will be			tour of duty. In addition, she		
		ift." On 3/7/11 additional			check 3 residents per week t		
		re added of "11. Fall			determine consistency of ala		
		t. 13. Lowered bed. 14.			checks, accurate placement		
		als in chair. 19. 2 staff to			alarms, whether or not the al	arms	
					are in working order, and		
	assist to toilet. 20	0. Medicine changed."			adequacy of fall risk interven		
					overall. If any issues are ider or observed, the DON or	ııııeu	
	The nurses' notes	s indicated on 4/10/11 at			designee will follow up as		
	11:00 A.M. "Cal	led to room as resident			indicated in question #2. On	the	
	got up to get wal	lker to go to bathroom.			week-ends and varioius shift	s, the	
		For walker, resident			charge nurse will be respons	ible	
	_	mat, falling into walker.			for checking the alarms for		
		cm. (centimeter) Lt (light)			placement and working order	r,	
		a to (L) (left) forehead			and for adequacy of fall risk interventions until IDT can		
	1 ^ ^	` ' ' '			review. The week-end mana	iger	
		n. skin tear to (L)			will also check at least 3 resi	•	
		ight headache. Neuro			during their tour of duty for a	larm	
		Sensor pad was on and			placement and working orde		
	1	ime. Then ambulated			results of these checks will b		
	with assist to bat	hroom"			brought to the next schedule		
					morning management meeting that meets at least 5 days a very service.		
	The incident/acc	ident report dated 4/10/11			for review by the interdiscipli		
	indicated "alarm	sounding - resident			team. Any recommendations		
	walking to walker & tripped on floor mat				made at that time will be follo	wed	
	causing her to fall into walker bumping				through by the DON. If a resi	dent	
	head on walker receiving 6 X 5 cm. raised			experiences a fall, the			
		_			investigation of the incident,		
	` ′	ead and 1.7 X 0.7 cm skin			well as review and updating resident's assessment and c		
	tear to (L) forear	m. No other injuries			resident s assessment and C	aıc	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155430 05/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 340 E 18TH ST HICKORY CREEK AT ROCHESTER ROCHESTER, IN46975 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE noted at this time able to move plan will be reviewed at the next scheduled morning management extremities per usual...." The section for meeting that occurs at least 5 "Additional comments and/steps to days a week. The IDT will prevent re-occurrence:" was blank. evaluate the fall interventions & update the care plan. Staff is notified by the Administrator and The fall investigation report dated 4/10/11 DON whenever a new indicated the sensor pad alarm was in use intervention is implemented – the and it sounded. The resident account of intervention is also placed on the the incident was "getting walker to go to CNA assignment sheet. Falls and interventions are also reviewed at bathroom." The conclusion was the fall the weekly Standards of Care was caused by the resident "got up meeting, which is attended by the unassisted." The prevention was "pick up IDT. 4. How will corrective action floor mat p (after) resident gets OObed be monitored to ensure the deficient practice does not recur (out of bed). and what QA will be put into place? The Administrator and During an interview with the LPN #1, on DON will bring the results of the monitoring rounds done by the 5/25/11 at 3:00 P.M., who wrote the notes nursing staff and IDT members to and did the initial assessment, she the Standards of Care meeting indicated Resident B had been sitting in each week and to the monthly her recliner at the foot of her bed, she got QA&A Committee meeting for up and walked to the head of her review and recommendations in process improvement. Any roommate's bed where her walker was recommendations made will be sitting. On her way she tripped on her followed up by the Administrator roommate's mat on the floor. She and DON who will report the indicated the roommate was in bed at the results of the improved process at the next QA&A Committee time. Resident B did not have a mat on meeting. This practice will the floor. She further indicated the floor continue on an ongoing basis. mat had been taped to the floor. She did The DON or designee will bring not know why Resident B's walker was on the results of their rounds and resident-specific audits to the her roommate's side of the bed. She monthly QA&A committee for indicated Resident B was not always further review & recommendation steady on her feet, even with the walker, for process improvement. Any and needed one person to walk with her. recommendations made will be followed up by the DON who will

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
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NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	•
				18TH ST	
HICKOR	Y CREEK AT ROCH	IESTER	ROCH	ESTER, IN46975	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ew interventions added to		report the results of the imporcess at the next QA&A	roved
	the care plan afte	er this fall.		Committee meeting. The QA	A&A
				Committee may stop the sp	• • • • • • • • • • • • • • • • • • •
	The nurses' notes	s indicated on 5/12/11 at		resident reviews after 90 da	
	9:00 P.M., "Resi	dent got self up to walk		when 100% compliance is	
	to room without	informing staff. Resident		achieved; however, continue	
	fell backwards -	hitting head - goose egg		monitoring of the alarm use during rounds will continue	
	noted to back of	head, Ice applied. Neuro		ongoing basis. Date of	511 411
		within parameters for		Compliance: 6/24/11	
		d up to feet - ambulated			
		d send resident to			
		valuation & treat"			
		WIWW			
	The ER history a	nd physical for 5/12/11			
	indicated "Fall (v				
	`	vith resultant 3 cm left			
	occipital parietal				
		eft shoulder contusion			
		Patient already is on a			
	Duragesic patch	for pain"			
	The incident/cas	ident investigation			
		larm was not in use," and			
		•			
	1 - 1	chair." "Resident in front			
		tion eating snack. Got up			
		ing to room. Fell over			
		g head - goose egg -			
		k of head" The			
		ments and/or steps taken			
	1 ^	urrence" section of the			
	report indicated,	"Make sure alarm on &			
	functioning." Th	e conclusion was "res			
	was agitated & g	ot up on own & fell."			
		vas "Remind staff to use			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/26/2	LETED
	PROVIDER OR SUPPLIER		B. WIN	340 E 1	DDRESS, CITY, STATE, ZIP CODE 8TH ST STER, IN46975		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
		transferred (Transfer					
	5/25/11 at 3:05 P had placed Resid of the nurses' sta LPN #1 was sitti but when she loo gone. She walke station through the corner, but when corner, Resident floor. She said the resident. The Ad- listening to the in was "human error	pleted on 5/13/11 for					
	1	indicated, "Pt. didn't in place. Pt. not therapy					
	There were no no the care plan after	ew interventions added to er this fall.					
	7:45 A.M., "Cha writer responded lying on floor in up against night headache. Noted	s indicated on 5/16/11 at ir alarm sounding. When to alarm - found resident room (number) with head stand. Voicing c/o d to have 1.5 cm diameter ek of head. Attempted to ident refused."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 05/26/2	LETED	
	PROVIDER OR SUPPLIER		•	340 E 1	DDRESS, CITY, STATE, ZIP CODE 8TH ST STER, IN46975	•	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B. CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
IAG	REGULATORY OR	LISC IDENTIFFING INFORMATION)		IAG	DEFICIE (CT)		DATE
	indicated "Alarn up and ambulate room next to her with head agains diameter raised a head" The sec comments and/o re-occurrence" v The fall investig indicated the res sounding. The other fall was "Resound own before staff section for "How	ident report dated 5/16/11 in sounding - resident got d to room (number) (the s). Found lying on back at night stand. 1.5 cm area noted to back of tion for "Additional r steps taken to prevent was blank. ation report dated 5/16/11 ident's alarm was on and conclusion of what caused so continues to get up on the can reach her." The will this incident be occurring again? had an					
	1 -	attempt to involve in					
	During an interv	iew with LPN #1 on					
	5/25/11 at 3:07 I	P.M., she indicated the					
	resident had bee	n sitting in her wheelchair					
	in front of her ro	om waiting to be taken to					
	the Dining Room	n for breakfast. She said					
	she was passing	trays and the CNA's were					
	in the back of the	e building on the other					
	1	eard Resident B's chair					
	alarm, but by the	e time she was able to get					
	1	B had walked from in					
	· ·	into the next resident's					
		llen. She indicated she					
		y the CNAs who had					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155430	A. BUILDIN	G	00	COMPL 05/26/2	
		100400	B. WING			03/20/2	
NAME OF I	PROVIDER OR SUPPLIER		I .		DDRESS, CITY, STATE, ZIP CODE		
HICKOR'	Y CREEK AT ROCH	FSTER			8TH ST STER, IN46975		
		TATEMENT OF DEFICIENCIES	II.				(V.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	placed her in her	wheelchair had not					
	moved her to the	dining room.					
	There was a care	plan for the problem of					
	"I am at increase	d risk for falls. I require					
	a pressure alarm	on my chair and on my					
		w intervention added on					
	5/16/11 of "Enco						
		ines, pictures, snacks,					
	drinks, etc."						
		5/05/11 0 . 40					
	~	on 5/25/11 at 3:40 p.m.,					
		ed she thought the					
		led to be busy to help					
	prevent the falls.						
	Review of the no	licy for "Fall Prevention					
		11/02 with the latest					
		7/09 indicated "It is the					
		ility to identify residents					
		nd to implement a fall					
		am to reduce the risk of					
		e injury." The procedure					
	1	s not limited to, "The					
	l '	Team (IDT) will review					
	1 .	risk prevention plan no					
	less often than qu	uarterly, as part (sic) the					
	care conference	the plan will be					
	reviewed and mo	dified as needed, after					
	each fall to make						
	interventions are	as current as					
	possibleThe D	ON will conduct the					
	· -	complete the back side					
	of the Fall Invest	igation Report					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLETE					
		155430	B. WING			05/26/2	011
	PROVIDER OR SUPPLIER			340 E 1			
	Y CREEK AT ROCH			ROCHE	STER, IN46975		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LGG INFORMATION	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCT		DATE
		will review the Fall					
	Investigation Rep						
	Interdisciplinary	ng management meeting					
	to develop a fall						
	including the dev	• •					
	_	revision of existing ones.					
		s identified as a need, the					
	_	s) will be scheduled at					
	that time"	,					
	This federal tag r	relates to Complaint					
	IN00090339.						
	3.1-45(a)(2)						
F0514		naintain clinical records on					
SS=D		ccordance with accepted ards and practices that are					
	•	ely documented; readily					
		stematically organized.					
	The clinical recent	must contain sufficient					
		must contain sufficient tify the resident; a record of					
	the resident's asse	essments; the plan of care					
	•	ded; the results of any					
	preadmission scre State; and progres	ening conducted by the					
		review and interview, the	F05	₅₁₄	<u>F 514</u>	l	06/24/2011
		have a complete record			<u> </u>		55,21,2011
					-		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155430	B. WIN			05/26/2011
			D. (111)		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1	8TH ST	
HICKOR'	Y CREEK AT ROCH	IESTER			ESTER, IN46975	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	.	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE .
	the care provided to a resident with a low				It is the policy of this facil	·
	1	n level for 1 of 1 resident			to maintain clinical records	
		by in a sample of 7			each resident in accordanc	
	(Resident B).				with accepted professional	
					standards and practices tha	it are
	Finding include:				complete, including assuri	ng a
					complete record regarding	care
	Resident B's clos	sed clinical record was			provided to residents with	low
	reviewed on 5/25	5/11 at 11:30 A.M.			oxygen saturation levels.	
	Resident B's dias	gnoses included, but were			1. What corrective action will be	<u>e</u>
	1	Izheimer's disease,			done by the facility?	
	•	ension, COPD (chronic			<u>-</u>	
		onary disease), paranoia,			Resident B is no longer a reside	ent of
	depression, and o				this facility.	
	depression, and e	ryspiiagia.			N	
	Dogidant Dig Ann	il 2011 and May 2011			Nursing staff will be	
		n orders indicated orders			in-serviced 6/15/11 to obtain	
	· ·	0/05/2010 for "O2			baseline oxygen saturation	
					parameters from the physic	cian
		(liters) via nasal cannula			when obtaining oxygen	
		NR (do not resuscitate)."			orders. In addition, the nu	
		ler dated 02/07/2011 for			have been in-serviced on the	he
	"Comfort care or	ıly."			need to document all	
					notifications of physicians	, as
	Nurses' notes ind				well as the physician's	
		I. " tx (treatment)			response to their notification	on.
	given for SOB (s	hortness of breath) O2			They have also been	
	(oxygen) sat (sat	uration) 65% on RA			in-serviced on documentin	g
	(room air)"				residents' refusal of service	~ I
	5/18/11 9:00 P.M	I. "68% RA. RR			medications, or treatments	·
	(respiratory rate)	28"			each time that this occurs.	
					in the time time over it.	
	RN #1 was interv	viewed on 5/25/11 at 2:45			2. How will the facility identify	other
		licated she had not called			residents having the potential to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		155430	A. BUILDING 00			COMPLETED - 05/26/2011	
155430			B. WING				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
HICKORY CREEK AT ROCHESTER			340 E 18TH ST ROCHESTER, IN46975				
	SUMMARY STATEMENT OF DEFICIENCIES			ID	(7/5)		
(X4) ID PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
	the physician about the low oxygen saturation levels nor had she started the oxygen because the resident didn't want the oxygen on and would take it off. She indicated she had not charted the				affected by the same practice ar	ı <u>d</u>	
					what corrective action will be ta	iken?	
					No other resident has been		
					affected. Each resident wit	h	
	resident's refusal of the use of the oxygen. During an interview with the				PRN oxygen order was		
					assessed for respiratory iss	ues	
					during survey. Oxygen	.	
	Administrator on 5/26/11 at 1:25 P.M., she indicated the physician knew of the resident's low oxygen saturation levels and he didn't want oxygen given. She provided a Progress Note written on 5/17/11 (a day before the nurses' notes for the low O2 saturation levels) indicating he was wanted to " continue Duragesic				saturations were taken, find	aing	
					all within normal range.		
					I d C d Cd DOM		
					In the future, if the DON f	inds	
					that there are no specific		
					oxygen parameters for oxy administrations when a	gen	
						.	
					resident has a PRN oxyger order, she will make sure t		
		th medication to control			the physician is notified as		
	• //	a narcotic to control pain)			soon as possible to obtain		
	to treat pain and suppress oxygen hunger."				those parameters.		
	She further indicated he knew Resident B had a low oxygen saturation levels,				those parameters.		
					Also, if she finds that		
		I the facility everyday			documentation of physicia	n	
	about his residents.				notification or residents'	-	
				refusal of services,			
		rd lacked a physician			medications, or treatments	is	
	level.	e resident's low oxygen			not completed, she will ma		
	ievei.				sure that the resident is saf		
	3.1-50(a)(1)				and taken care of		
	3.1-50(a)(1) 3.1-50(a)(2)				appropriately.		
	3.1-30(a)(2) 3.1-50(f)(5)						
	J.1-JU(1)(J)				Once both of these situation	ns	
					are addressed, the DON wi	11	
					review and re-inservice the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155430		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/26/2011			
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN46975				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION	N	
	RESOLUTION OR			nurse(s) involved in the facility policy and experior these situations. She also address the noncompliance with progressive disciplinary. 3. What measures will into place to ensure the practice does not recurred. When baseline parametere every from the physician oxygen saturation level nurses will follow their treating the resident are notifying the physician event that no baseline saturation level has be established, the nurse contact the physician whenever the oxygen saturation level drops 90%. The DON will review hour report and focus at least 5 days a week of her tour of duty. If sidentifies any issue regarded the administration of completion in docume of physician notification.	electation ne will ry action. be put is r? eters are sician for els, the m when nd n. In the oxygen en will below the 24 charting as part she garding oxygen e of entation		

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	00	COMPLETED	
		155430	A. BUILDING B. WING		05/26/2011	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN46975			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				resident's refusal of treatm or services, she will addre the situation immediately indicated in question #2. She will bring the results of her review to the morning management meeting that occurs at least 5 days a we with the interdisciplinary of for further review and recommendations. The ID will evaluate the situation provide any other intervent that are believed to be necessary to better meet the need of the resident involved. Staff will be notified by the DON whenever a new intervention is implemented the intervention will be placed on the CNA assignment shas well. 4. How will corrective act be monitored to ensure the deficient practice does not recur and what QA will be into place? The DON will bring the record of her reviews to the mont QA&A committee for	nent ss as of eek eeam T and ations ae yed. ae ed — aced aced aeet sput esults	

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PRINTED: 06/16/2011 FORM APPROVED OMB NO. 0938-0391

		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	A. BUILDING B. WING	00	COMP 05/26/2	LETED	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER			STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN46975				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE	
				recommendations for primprovement. Any recommendations made be followed up by the who will report the rest the improved process an next QA&A Committed meeting. This will comman ongoing basis. Date of Compliance: 6	e will DON ults of at the e tinue on		